

PHP68 **THE USE OF HEALTH ECONOMICS TERMINOLOGY IN CLINICAL PUBLICATIONS: BRIDGING THE GAP FROM CLINICAL EFFECTIVENESS TO COMPARATIVE EFFECTIVENESS**

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OBJECTIVES: As the demands of the current regulatory climate and US Health Care Reform call for greater outcomes-based evidence in health care, the scientific literature is increasingly incorporating pharmacoeconomic data into peer-reviewed clinical publications in order to demonstrate value to payer audiences. Data from clinical outcomes and cost studies are increasingly finding their way into traditional clinical papers and review articles. It has been observed that variations may exist in the use of health outcomes data and terminology. The purpose of this presentation will be to demonstrate how clearer and more consistent terminology can be integrated into scientific publications and other vehicles in order to more effectively communicate economic and clinical outcomes information. **METHODS:** Using specific examples from clinical publications, the presentation will: Identify and analyze common terms used for communicating health economic and outcomes research information to determine; If they have multiple and/or unclear meanings; How they are being used to convey information; Define the specific meaning of these terms, using language that is understandable to all stakeholder audiences; Provide examples/case studies demonstrating how more uniform and consistent definitions can be integrated into payer-focused clinical publications **RESULTS:** An overview of the findings regarding how to address specific areas of confusion and inconsistency will be provided. **CONCLUSIONS:** The results will reiterate the need for clear and consistent terminology in communicating value in clinical publications.

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MOBILE MEDICAL RECORD—A LIFE SAVING TOOL

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BACKGROUND: An emergency services team is launched to treat a man who collapsed in the street. The team takes John Doe's mobile phone, and within seconds retrieves the required clinical parameters from his Mobile Medical Record (MMR) thus providing a life-saving treatment suited to his personal health condition. Have the necessary clinical parameters, required at emergency situations, ever been examined in order to best match both emergency situations and cellular technology? **OBJECTIVES:** Characterization of the clinical parameters which assemble an MMR in the context of saving life and propose a model for an MMR in emergency medicine. **METHODS:** Characterization of the essential emergency medicine clinical parameters in the context of life-saving treatments, through interviews with prehospital and hospital experts in emergency medicine. Supported by a Cellular multimedia expert, analysis of the results in order to incorporate the clinical parameters into the cellular world as an MMR. **RESULTS:** Emergency medicine teams chose individual and specific clinical parameters in a certain order of appearance from the general medical record which should assemble, in their opinion, emergency medicine MMR. MMR was chosen by the emergency medicine treatment teams as one of their preferred communication method among the possible communication methods presenting a patient medical record in the context of life-saving treatment. **CONCLUSIONS:** The MMR model, if applied correctly, will provide the emergency medicine treatment teams an available, reliable, homogeneous database of real time clinical parameters adapted to life-saving conditions. The MMR model represents a conceptual revolution of taking out the medical record from the caregiver and transferring it to the patient, which can be constantly at hand at any given time or place. By doing so, the MMR contributes and becomes integrated with the leading approaches in the world of medicine supporting a patient-centered care policy.

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CURRENT TRENDS IN HEALTH TECHNOLOGY INCORPORATION (HTI) IN BRAZIL: INSIDE THE NATIONAL HEALTH SYSTEM'S (NHS) BLACK BOX

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OBJECTIVES: We aimed to evaluate the trends of submissions and recommendations received and emitted by the Brazilian Commission on Health Technology Incorporation (CITEC) during the process of adoption/exclusion of technologies on the country's Public Health System and to critically appraise this process and to analyze the challenges this commission faces in responding to the increased demand for incorporation of new technologies. **METHODS:** All submissions on health technologies made to CITEC and the respective responses obtained between 2003 and 2010 were reviewed. They were classified by field of interest, origin of request and type of response. **RESULTS:** During the selected period CITEC received 222 proposals for technology incorporation and produced 83 recommendations. We identified an increase in submissions after 2007. From 2003 to 2006, only 39 requests were submitted on total. After 2007, an average of 49 submissions per year was made. The main fields were endocrine and metabolic disorders (12%), Oncology (11%) and Rheumatology (11%), but the percentage of responses in these fields was low (34%, 8% and 28% respectively). More than 70% of the submissions were commissioned by the Industry (162), but only 27% of these were answered. However, almost all submissions sent directly by the Ministry of Health were answered (94%). Among recommendations from CITEC, 53% were favorable to the incorporation of the new

technology and 30% were contrary to it, 17% were cancelled submissions. Adopted technologies were mainly for hepatitis (14%), endocrine and metabolic disorders (11%) and genetic disorders (11%). **CONCLUSIONS:** Although there isn't a clear definition of priorities for the incorporation of new technologies by the Brazilian Ministry of Health, it is possible to map trends in the recommendations issued by CITEC. It is of the utmost importance to achieve greater disclosure of the criteria for selection of technologies for incorporation by the Commission.

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PREDICTING OUTCOMES AMONG PATIENTS WITH PROLONGED MECHANIC VENTILATION: A DISCRIMINATION MODEL BASED ON LONGITUDINAL HEALTH INSURANCE REGISTRATION AND CLAIMS DATA

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OBJECTIVES: To identify patients with low survival probability among those with prolonged mechanical ventilation (PMV; ≥ 21 days of use) under the Taiwan National Health Insurance (NHI), and explore the length of their time free of inpatient mechanical ventilation (MV) and MV-related hospital expenses during the four years following PMV. **METHODS:** This is a retrospective cohort study using death certificates data and longitudinal NHI data for a national representative sample of 25,482 new PMV patients in 1998–2003. Logit regression was used to determine factors associated with 3-month, 6-month, 1-year and 2-year survival. Explanatory factors included hospital characteristics, and individual demographics, socioeconomic conditions, diseases at the PMV onset, and diseases causing hospital care use within the year before PMV. The probability cutoff was set at 10% for identifying patients with low survival likelihood and suitable as targets of advocating less intensive care. **RESULTS:** Five disease types had high prevalence, and were significantly associated with lower survival: septicemia, neoplasm, shock, acute and unspecified renal failure, and chronic renal failure. Each had an odds ratio < 0.65 ($p < 0.001$). Non-alcohol-related liver disease was also a significant problem. Each survival model had a C-statistic ≥ 0.7 . At the 10% probability cutoff, 1.5%, 5.1%, 11.9% and 21.8% of PMV patients were identified as negative cases for 3-month, 6-month, 1-year and 2-year survival. The negative predictive values were 86.5%, 86.1%, 89.4%, and 91.8%, respectively. During the four years after PMV, 75% of these patients had 25 or fewer days free of MV-related hospital care, and more than 50% of them spent at least 10,800 dollars (2010 USD) on MV-related hospital care. **CONCLUSIONS:** This discrimination model has acceptable performance. It helps in selecting potential targets for advocating less intensive care, and also generates more empirical evidence on prognosis that can facilitate patient-clinician and family-clinician communication.

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ANALYSIS THE AVERAGE SOJOURN TIME AND BOTTLENECK AFTER A DISASTER IN HOSPITALS

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OBJECTIVES: The purpose of this study is to consider the average sojourn time of patients figure out hospital's function after a disaster striking. **METHODS:** This study explores the average sojourn time of patients and bottleneck in hospitals in the region defined by this study. Especially, we focus on three days after a disaster striking the region. We defined three scenarios. • Scenario I: Hospital No. II ceases to function two days from disaster strikes. • Scenario II: Hospital No. II ceases to function one day from disaster strikes. • Scenario III: Scenario III is the same scenario as the scenario I, but considering transport from break down hospital (hospital No. 2) to hospitals in operation. Patient's arrival interval λ and treatment time μ are equal to the data of Hanshin earthquake. With the use of those scenarios, we analyze the average sojourn time of patients and bottleneck with a queuing approach, critical path method and Little's law. In addition to that, we make Cumulative flow graph to analyze bottleneck. **RESULTS:** Comparing scenario I and scenario III, the average sojourn time of general hospital of scenario III is longer than scenario I, although scenario III has more choices. It reveals considering transport from break down hospitals to hospitals in operation extends the average sojourn time. We observed bottleneck in case of changing patient's arrival interval λ by making cumulative flow graph. This study shows cumulative flow graph reveals status of hospital's function after a disaster. **CONCLUSIONS:** The results confirm that the average sojourn time of patients increase in case of changing hospital, Braess's paradox and cumulative flow graph reveals status of hospital's function after a disaster.

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CONTENT OF HOME PHARMACIES IN SERBIA

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OBJECTIVES: To get insight into the amount, structure and financial aspects of medicines in home pharmacies as well as learning about the population's attitudes, habits and knowledge concerning self-medication. **METHODS:** This survey was conducted in the first half of 2010. on a sample of 50 families on the territory of Novi Sad, Serbia. The families were chosen randomly and the data were collected by using the standardized questionnaire and checking the inventory of medicines. **RESULTS:** The average number of packets in home pharmacies per a family is considerable (13